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IN THE
Supreme Court of the United States
OCTOBER TERM, 1994

ROBERT C. METCALF, DIRECTOR
VIRGINIA DEPARTMENT OF
MEDICAL ASSISTANT SERVICES,
Petitioner,

v.

REHABILITATION ASSOCIATION
OF VIRGINIA, INCORPORATED,
Respondent.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

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BRIEF OF *AMICI CURIAE* STATES OF ALABAMA, ILLINOIS, KANSAS, MARYLAND, MICHIGAN, OREGON, IN SUPPORT OF PETITIONER

JEFF SESSIONS
Attorney General of Alabama
State House
11 South Union Street
Montgomery, AL 36130
(334) 242-7401

JAMES H. MCLEMORE *
Deputy Attorney General
CAPELL, HOWARD, KNABE
& COBBS, P.A.
57 Adams Avenue
Montgomery, AL 36104
(334) 241-8000

* Counsel of Record

[Additional Counsel Listed on Inside Cover]

WILSON - EPES PRINTING CO., INC. - 789-0096 - WASHINGTON, D.C. 20001

HONORABLE JAMES E. RYAN
Office of the Attorney General
160 N. Lasalle Street
Suite N1000
Chicago, IL 60601

HONORABLE CARLA J. STOVALL
Office of the Attorney General
Judicial Building
301 West Tenth Street
Topeka, KS 66612-1597

HONORABLE J. JOSEPH CURRAN, JR.
Office of the Attorney General
200 Saint Paul Place
Baltimore, MD 21202-2202

HONORABLE FRANK J. KELLEY
Office of the Attorney General
Post Office Box 30212
525 West Ottawa Street
Lansing, MI 48909

HONORABLE
THEODORE R. KULONGOSKI
Office of the Attorney General
Justice Building
1162 Court Street, NE
Salem, OR 97310

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BRIEF OF *AMICI CURIAE* STATES OF ALABAMA, ILLINOIS, KANSAS, MARYLAND, MICHIGAN, OREGON, IN SUPPORT OF PETITIONER

INTEREST OF AMICI CURIAE

This brief by Alabama, Illinois, Kansas, Maryland, Michigan, and Oregon is submitted pursuant to Supreme Court Rule 37 in support of the petition for writ of certiorari filed by Virginia, seeking review of the court of appeals decision in *Rehabilitation Ass'n of Virginia v. Kozlowski*, 42 F.3d 1444 (4th Cir. 1994).

All fifty states participate in the Medicaid program, a joint state-federal program under Title XIX of the Social Security Act of 1965, 42 U.S.C. 1396a, *et seq.* Many have rules similar to Virginia's rule limiting co-payments for Qualified Medicare Beneficiaries ("QMBs")[1] to the Medicaid rate. All will be subject to potentially dramatic increases in litigation if Medicaid providers are allowed the expansive standing to file suit implicit in the decision by the Fourth Circuit. The Amici States also have a substantial financial interest in this case. Their state treasuries—and the pocketbooks of their citizens—are exposed to the burden of a multi-billion dollar increase in Medicaid costs implicated by the interpretation embraced by the Fourth Circuit. *See* Pet. 18-19. A decision by this Court on the validity of the rule adopted by the Commonwealth of Virginia will directly address the validity of rules promulgated by the Amici States.

In addition, the issue whether health care providers have a private right of action under 42 U.S.C. § 1983 to challenge the rule in question will directly impact pending cases by health care providers on the same issue. *Michigan Ass'n of Ambulance Servs. v. State of Michigan,* No. 5:95-CV-48 (W.D. Mich. filed Apr. 10, 1995); *Maryland Psychiatric v. Wasserman and Shalala,* No. S 95-894 (D. Md. filed Mar. 24, 1995) and *Paramount Health Sys. v. Wright and Shalala,* No. 95-C-1620 (N.D. Ill. filed Mar. 14, 1995). The Fourth Circuit's ruling destroys the integrity of the rights analysis set forth in *Wilder v. Virginia Hosp. Ass'n,* 496 U.S. 498 (1990) and *Suter v. Artist M.,* 503 U.S. 347 (1992). Specifically, by permitting health care providers to challenge State

[1] The terms "Qualified Medicare Beneficiary" and "QMB," as used herein, have the same meaning as in the petition for writ of certiorari. The terms include those who are eligible for both Medicaid and Medicare ("dual eligibles") as well as those elderly and disabled poor who are not Medicaid eligible, but who still fall under the federal poverty line. *See* Pet. 5 n.2.

Medicaid Plans by asserting the rights of QMBs, the Fourth Circuit has taken far more liberties with Medicaid statutory language than the holding in *Wilder*. *See Wilder*, 496 U.S. at 528-529 (Rehnquist, C.J., dissenting). This issue directly affects every state which participates in the Medicaid program.

For the above reasons, the Amici States have a direct and abiding interest in the issue now before this Court.

SUMMARY OF ARGUMENT

At issue before this Court is the ruling of the Fourth Circuit, creating an enforceable right of health care providers to sue under § 1983, that goes beyond the holding of this Court in *Wilder*. The Fourth Circuit's ruling turns *Wilder* on its head. Its expansive statement of the standing rule for claims based upon the buy-in provisions is an open invitation to health care providers to bring suit on all aspects of the reimbursement program:

> Where the state refuses to pay what the providers insist is the proper amount of the copayment for QMBs required under the Medicaid Act, the providers have standing to challenge the state's interpretation of the relevant provisions.

Rehabilitation Ass'n, 42 F.3d at 1450; Pet. App. 12.

This ruling has already had the effect of encouraging providers to bring § 1983 claims on state buy-in program provisions other than those at issue in *Rehabilitation Ass'n*. In Maryland, providers have filed suit against the federal Secretary of Health and Human Services and the Secretary of the State Department of Health and Mental Hygiene, alleging that they have standing to challenge the federal and state reimbursements policy for outpatient psychiatric services to QMBs. This suit was filed even though, in Maryland, the Medicaid program actually pays the full 20% of the amount allowed by Medicare for such services. *Maryland Phychiatric Society v. Wasser-*

man and Shalala, No. S 95-894 (D. Md., filed March 24, 1995). Like the majority opinion in *Rehabilitation Ass'n*, the *Maryland Psychiatric* complaint repeatedly asserts that the buy-in program legislation was intended to benefit poor recipients of medical care. *See Rehabilitation Ass'n*, 42 F.3d at 1447, 1451-1452, 1455, 1458-1459; Pet. App. 4-6, 15-20, 25-28, 33-38. Yet, it alleges that this statute, which is intended to benefit recipients, creates a cause of action for health care providers—ignoring the *Wilder* rule that, in order for a plaintiff to have an enforceable right, the provision in question must be intended to benefit the plaintiff. *Wilder*, 496 U.S. at 508.

The Secretary of Health and Human Services ("the Secretary") is entitled to deference on the meaning of the statutes here at issue under the rule of *Chevron U.S.A., Inc. v. National Resources Defense Council, Inc.*, 467 U.S. 837 (1984). Respondent's efforts to deny the Secretary such deference must fail because it does not—and cannot—demonstrate that its position was unambiguously written into the statutes by Congress.

Despite the apparent agreement among four circuits on the Medicaid cap issue, the rationales underlying their rulings are contradictory. Thus, the states are left with the prospect of additional litigation by providers seeking greater reimbursement under the Medicare and Medicaid statutes.

ARGUMENT

I. THIS COURT'S HOLDING IN *WILDER* DOES NOT GIVE MEDICAL PROVIDERS A RIGHT TO SUE IN THIS CASE.

An alleged violation of federal law is not enough to confer standing. *Wilder*, 496 U.S. at 509 (citing *Golden State Transit Corp. v. Los Angeles*, 493 U.S. 103 (1989)). However, § 1983 provides a cause of action for violations of federal statutes that unambiguously create an enforceable right. *Wilder*, 496 U.S. at 508. A federal statute creates an enforceable right if (1) the statute is intended to benefit the plaintiff at bar, (2) the statute imposes a binding obligation on the state, and (3) the interest the plaintiff asserts is not too vague and amorphous that it is beyond the competence of the judiciary to enforce. *Id.* In deciding whether § 1983 applies, a court must interpret each statute by its own terms. *Suter*, 503 U.S. at 358.

The Medicaid Act does not expressly create a right of action for health care providers. In *Wilder*, this Court held that the Boren Amendment implicitly created an enforceable right on the part of providers seeking reimbursement to challenge rates set by the States. *See Suter*, 503 U.S. at 357 (citing *Wilder*, 496 U.S. at 503). Respondent asserts that "*Wilder* makes clear that its *holding* is not limited to challenges brought under the Boren Amendment. . . ." Resp't Br. 13. (Emphasis added.) With all due respect, Respondent confuses the *holding* of a case with its *dictum*. The holding in *Wilder* is limited to the Boren Amendment, the statute then before the Court for construction. Other language in *Wilder* suggesting a more comprehensive standing to sue is *dictum*.

The cost-sharing provision at issue today appears in a markedly different context than the cost reimbursement provision in *Wilder*. Whereas the Boren Amendment provision in *Wilder* addressed a payment system that ex-

pressly paid health care providers, the provision at issue in the case at bar is phrased in terms of qualified Medicare beneficiaries:

> A State plan for medical assistance must—(10) provide—(E)(i) for making medical assistance available for medicare cost-sharing (as defined in [§ 1396d(p)(3)]) for qualified medicare beneficiaries described in [§ 1396d(p)(1)].

42 U.S.C. § 1396a(a)(10)(E)(i). This provision is not "part of a system of reimbursement" (as the Respondent incorrectly contends in its Brief in Opposition; Resp't Br. 14), nor does it pertain to the rights of health care providers to reimbursement of their reasonable costs (as the Fourth Circuit incorrectly held below). Instead, this provision pertains to the rights of QMBs to certain amounts of medical assistance.

The Amici States have the benefit of the Brief in Opposition filed by the Respondent. Respondent's argument that the QMB cost-sharing provision can only be interpreted as benefiting providers because it is necessarily the providers who incur those costs completely ignores the stated purpose of the Medicaid program:

> For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self care . . . .

42 U.S.C. § 1396. If this express purpose is disregarded, Respondent's logic could be applied to the entire Medicaid program and dramatically expand *Wilder*. Changing Medicaid from a program for providing financial assistance to people unable to pay for necessary medical serv-

ices into a program for ensuring the well-being of health care providers is not a goal the federal judiciary should undertake.

In *Suter*, this Court held that private individuals did not have a right to enforce a provision of the Adoption Assistance and Child Welfare Act either under the Act or under § 1983. In reaching such a result, the Court carefully examined its decision in *Wilder* and commented that *Wilder* "took great pains" to analyze the statutory provisions of the Boren Amendment in light of "the entire legislative enactment." *Suter*, 503 U.S. at 357. Despite the fact that the provision at issue today is not even part of the Boren Amendment, the Fourth Circuit has engaged in no such painstaking analysis. Instead, it summarily concluded that the analysis set out by the Fourth Circuit and Supreme Court in *Wilder*, as to the Boren Amendment, is "equally applicable in this instance to the related QMB provisions of 42 U.S.C. §§ 1396a(a)(10)(E), 1396d(a), 1396d(p)." *Rehabilitation Ass'n*, 42 F.3d at 1450; Pet. App. 12. This conclusion represents an inexplicable departure from the methodical approach followed by the Court in *Suter*.

Finally, Respondent urges this Court to deny certiorari on the Medicaid rate limitation issue based in part on its previous denial of certiorari in *New York City Health & Hosp. Corp. v. Perales*, 954 F.2d 454 (2d Cir.), *cert. denied*, —— U.S. ——, 113 S. Ct. 461 (1992). Resp't Br 1-2. Yet, Respondent ignores the fact that the *Perales* case—unlike the case at bar—never placed the issue of standing before this Court for its consideration.

II. THE RESPONDENT HAS FAILED TO DEMONSTRATE THAT THE STATUTES AT ISSUE UNAMBIGUOUSLY REFLECT ITS POSITION SO AS TO JUSTIFY DENYING DEFERENCE TO THE SECRETARY.

Respondent's brief confirms the paucity of its claim that the federal Secretary should be denied deference on the meaning of the statutes here at issue. In trying to explain its view that Congress was unambiguous, the Respondent has merely highlighted the ambiguity that pervades these statutes, aptly described by the Fourth Circuit as "among the most completely impenetrable texts within human experience." Pet. App. 12. The Amici States will address each of the Respondent's points in turn.

(i) The Respondent states "[t]here is *unanimity* that for the 20 years prior to the 1986 QMB amendments, states were required to Pay Part A *and* Part B cost-sharing in full for all dual eligibles." Resp't Br. 16 (first emphasis added). There is no such unanimity. As the Respondent should know, this issue is hotly contested. Indeed, in the very segment of the Fourth Circuit opinion cited by the Respondent, that court took note of the Secretary's view that "state contribution towards Part B was completely optional." Pet. App. 16. Thus, for the Respondent to use an alleged unanimity about the pre-1986 meaning of the law as a baseline for the meaning of subsequent changes is misleading and should be disregarded.[2] Moreover, this case is not about what the law meant before 1986, but what the law means today, after

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[2] Even if the Respondent's reference to the 20 years prior to 1986 were only intended to reach back to the 1967 amendment, there would be no unanimity for the proposition cited. For example, even the Fourth Circuit takes the view that, during the period between 1967 and 1986, "the States' required contribution under the buy-in included . . . cost-sharing on either a full basis *or less than full basis* . . . ." Pet. App. 20 (emphasis added).

numerous legislative changes that do not necessarily reflect a consistent policy direction.

(ii) The Respondent states that "[i]n 1986, Congress sought to *broaden* the protected class by creating QMBs (elderly poor but ineligible for Medicaid)." Resp't Br. 17 (emphasis in original). It is true that the 1986 adoption of 42 U.S.C. § 1396a(a)(10)(E) allowed this joint federal-state program to provide such broader coverage "at the option of a State." But, to acknowledge "broader" coverage begs the question. Just how broad was it?

(iii) The Respondent seeks to answer this question about the breadth of coverage after 1986 by asserting that "states opting to cover QMBs 'must' *pay all* Medicare cost-sharing . . . ." Resp't Br. 17 (emphasis added). Respondent's use of the words "pay" and "all" is a verbal sleight of hand. Section 1396a(a)(10)(E) does not talk in terms of "paying all" medicare cost-sharing. Instead, it talks in terms of "making medical assistance available" for such cost-sharing. The distinction is crucial because the term "medical assistance" expressly incorporates the concept of less than full payment. As defined in 42 U.S.C. § 1396d(a), " 'medical assistance' means payment of *part or all* of the cost of [certain] care and services . . . ." (Emphasis added.)

Respondent claims that this reference to "part or all" means only that states are permitted to "offload some nominal portion of their obligation to pay the cost-sharing amounts on the dual eligibles/QMBs . . . ." Resp't Br. 17 n.8. That is one interpretation. A better interpretation is that the mention of partial payment is intended, *inter alia*, to refer to situations where states exercise their option—which the Secretary and the Amici contend states have under § 1396a(n)—not to pay in excess of the Medicaid rates.[3] Moreover, if faced with a choice be-

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[3] 42 U.S.C. § 1396a(n) provides: "Payment amounts. In the case of medical assistance furnished under this title [Medicaid] for

tween these two interpretations, surely one cannot say that the one favored by the Respondent is unambiguously compelled by the language of the statute. Given the deference to which the Secretary is entitled, her view must prevail. States have the option she says they have under § 1396a(n).

(iv) Respondent's fourth point challenges Virginia's use of a 1988 committee report as an indication of Congressional intent. Resp't Br. 18. In so doing, it seeks to dismiss—without addressing—Virginia's key point: that the *1988 report* is a legitimate guide to what the *1988 Congress* meant when it voted to impose a new obligation on the states. *See* Pet. 8. The *alternative* position—which is so untenable that the Respondent does not dare express it outright—is that some Congress serving *before* 1988 knew better than the 1988 Congress what the 1988 Congress meant when it imposed that new obligation.[4] Such "predictive history" is wholly unreliable.[5] Indeed, the concept is oxymoronic.

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medicare cost-sharing respecting the furnishing of a service or item to a qualified medicare beneficiary, the State plan may provide payment in an amount with respect to the service or item that results in the sum of such payment amount and any amount of payment made under title XVIII [Medicare] with respect to the service or item exceeding the amount that is otherwise payable under the State plan for the item or service for eligible individuals who are not qualified medicare beneficiaries." (Emphasis added).

[4] The Fourth Circuit is not quite so reticent. It relies on the 1986 committee report as a guide to the meaning of the optional QMB buy-in program adopted that year by Congress, as well as the meaning of the mandatory program not adopted until 1988. *See* Pet. App. 26-31.

[5] Where the difference between earlier legislation and a later amendment is minor, it may make sense to rely on the interpretation articulated in the earlier committee report for a basic understanding of the later statute. But, where the difference between the earlier and later versions of a law is fundamental—such as a difference between optional rights and mandatory duties—then the

(v) Respondent's fifth point does not relate to ambiguity, but replies to Virginia's suggestion that those courts denying deference to the Secretary have been motivated in part by a policy preference that is inappropriate for the judiciary to make. Resp't Br. 19; Pet. 21. In so doing, Respondent cites language from the Fourth Circuit denying any such purpose, while ignoring the explicit policy preferences made by other judges on whom Respondent relies to discourage the granting of certiorari. *See New York City Health & Hosp. Corp. v. Perales*, 954 F.2d 854, 859 (2d. Cir.), cert. denied, —— U.S. ——, 113 S. Ct. 461 (1992); Pet. 20; Resp't Br. 8. Moreover, in the same sentence that the Fourth Circuit majority disclaims any policy preference, it describes its position as being "in accord with all common sense," a clue that policy preferences may be at work here after all. Pet. App. 34. Any discussion about common sense should, of course, take into account the billions of dollars in additional costs that would result from the policy the Respondent ascribes to Congress, Pet. 18-19, something the Fourth Circuit majority overlooks. Under § 1396, Medicaid intended to take into account the conditions in the participating states, implicitly including financial conditions. Thus, these high costs are an appropriate factor in analyzing the meaning of the statute. They are also a factor that underscores the importance of this case and that the Amici States believe should help persuade this Court to grant certiorari.

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later committee report, which Congress presumably consulted before enacting those duties, should be regarded as a reliable guide to what Congress intended to do. If, on the other hand, it could be presumed that Congress ignores a committee report at such a critical juncture, then the value of all committee reports would be called into question. The resulting lack of guidance to the judiciary would be another reason for deferring to the interpretation of the Secretary.

III. THERE IS NO UNANIMITY AMONG THE CIRCUITS AS TO WHETHER MEDICAID PROVIDERS ARE ENTITLED TO 100% REIMBURSEMENT UNDER THE MEDICARE PROGRAM.

While four federal circuits do not diverge on the specific issue of Medicaid payment of the 20% coinsurance amount for QMBs, the rationales underlying their rulings are contradictory. As a result, states are left uncertain as to the effect of the ruling on other aspects of the buy-in program, and are subject to additional litigation by providers seeking to gain greater reimbursement for their professional services under various provisions of the Medicare and Medicaid statutes.

In *Perales*, the Second Circuit Court ruled, very broadly, that "providers who furnish medical care to Medicare-eligible patients have the right to collect 100% of their reasonable costs or charges." 954 F.2d at 858. The Third and Eleventh Circuit Courts adopted this rule without analysis. *See Snider*, 29 F.3d at 891; *Haynes*, 36 F.3d at 1076. However, the cases relied upon by the *Perales* court were claims brought by hospitals for revision of the calculation of their reimbursable costs, in light of the Medicare policy against cost-shifting between Medicare and non-Medicare patients. *See Mercy Community Hosp. v. Heckler*, 781 F.2d 1552 (11th Cir. 1986); *St. James Hosp. v. Heckler*, 760 F.2d 1460 (7th Cir.), *cert. denied*, 474 U.S. 902 (1985); *Menorah Medical Ctr. v. Heckler*, 768 F.2d 292 (8th Cir. 1985); *Regents of Univ. of Cal. v. Heckler*, 771 F.2d 1182 (9th Cir. 1985); *see* 42 U.S.C. §§ 1395f(b)(1); 1395x(v)(1)(A). These cases had nothing to do with the buy-in program; the so-called "right" to 100% reimbursement has been imported wholesale from one aspect of the straight Medicare program into the joint Medicare/Medicaid buy-in program, with no analysis of the distinctions between the two programs.

Moreover, the Fourth Circuit in *Rehabilitation Ass'n* seems to have recognized that the *Perales* reliance upon

the 100% reimbursement guarantee was faulty. In his dissent, Judge Niemeyer points out:

> The majority opinion, in affirming the district court's judgment, does not rely, quite properly I believe, upon the argument raised by the Rehabilitation Association and relied on by Perales that the Secretary's policy violates the Medicare Act by denying to health care providers the full reasonable value of their services.

42 F.3d at 1465 n.3; Pet. App. 52 n.3. Indeed, nowhere in the majority opinion does the court cite this purported right to 100% reimbursement. Thus, the circuit courts apparently disagree as to whether providers have any absolute guarantee of 100% reimbursement for services to QMBs under the buy-in program.

CONCLUSION

The decision of the Court of Appeals presented for review has afforded health care providers a right of action under a section of the Medicaid Act where no such right lies. The decision expands this Court's decision in *Wilder* so dramatically as to transform the Medicaid program, as a whole, from a program designed principally to assist people unable to afford medical care, to a program designed to benefit health care providers. Moreover, Respondent has utterly failed to prove its assertion that Congress unambiguously enacted into law the interpretation by which Respondent seeks more money for its members. Its ineffective attempt to do so merely confirms the need for deference to the interpretation of the federal Secretary. For all of the foregoing reasons, the Amici States urge this Court to grant certiorari and to overturn the decision of the Fourth Circuit in favor of the position advocated by the Secretary and by Virginia.

Respectfully submitted,

JEFF SESSIONS
Attorney General of Alabama
State House
11 South Union Street
Montgomery, AL 36130
(334) 242-7401

JAMES H. MCLEMORE *
Deputy Attorney General
CAPELL, HOWARD, KNABE
& COBBS, P.A.
57 Adams Avenue
Montgomery, AL 36104
(334) 241-8000

HONORABLE JAMES E. RYAN
Office of the Attorney General
160 N. Lasalle Street
Suite N1000
Chicago, IL 60601

HONORABLE CARLA J. STOVALL
Office of the Attorney General
Judicial Building
301 West Tenth Street
Topeka, KS 66612-1597

HONORABLE J. JOSEPH CURRAN, JR.
Office of the Attorney General
200 Saint Paul Place
Baltimore, MD 21202-2202

HONORABLE FRANK J. KELLEY
Office of the Attorney General
Post Office Box 30212
525 West Ottawa Street
Lansing, MI 48909

HONORABLE
THEODORE R. KULONGOSKI
Office of the Attorney General
Justice Building
1162 Court Street, NE
Salem, OR 97310

* Counsel of Record